Patient Name:_____ **Date of Birth**_____

Dental History (New Patients Only)

Reason for today's visit_____How often do you floss?_____brush?_____

Former Dentist Name_____City/State_____

Date of Last Visit_____ Date of Last X-rays_____

Bad Breath	☐Yes ☐No	Food collection between teeth	☐Yes ☐No	Mouth pain, brushing	☐Yes ☐No
Bleeding Gums	☐Yes ☐No	Foreign objects	☐Yes ☐No	Orthodontic treatment	☐Yes ☐No
Blisters on lips or mouth	☐Yes ☐No	Grinding teeth	☐Yes ☐No	Pain around ear	☐Yes ☐No
Burning sensation on tongue	☐Yes ☐No	Gums swollen or tender	☐Yes ☐No	Periodontal treatment	☐Yes ☐No
Chew on one side of mouth	☐Yes ☐No	Jaw pain or tiredness	☐Yes ☐No	Sensitivity to cold	☐Yes ☐No
Cigarette, pipe, or cigar smoking	☐Yes ☐No	Lip or cheek biting	☐Yes ☐No	Sensitivity to heat	☐Yes ☐No
Clicking or popping jaw	☐Yes ☐No	Loose teeth or broken fillings	☐Yes ☐No	Sensitivity to sweets	☐Yes ☐No
Dry mouth	☐Yes ☐No	Mouth breathing	☐Yes ☐No	Sensitivity when biting	☐Yes ☐No
Fingernail biting	☐Yes ☐No			Sores or growths in mouth	☐Yes ☐No

Health History

Physician's Name_____

Address_____ Date of Last Visit_____

AIDS/HIV	☐Yes ☐No	Epilepsy	☐Yes ☐No	Psychiatric Care	☐Yes ☐No
Anemia	☐Yes ☐No	Fainting or dizziness	☐Yes ☐No	Radiation Treatment	☐Yes ☐No
Arthritis, Rheumatism	☐Yes ☐No	Glaucoma	☐Yes ☐No	Respiratory Disease	☐Yes ☐No
Artificial Heart Valves	☐Yes ☐No	Headaches	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Artificial Joints	☐Yes ☐No	Heart Murmur	☐Yes ☐No	Scarlet Fever	☐Yes ☐No
Asthma	☐Yes ☐No	Heart Problems	☐Yes ☐No	Shortness of Breath	☐Yes ☐No
Back Problems	☐Yes ☐No	Specify_____		Sinus Trouble	☐Yes ☐No
Bleeding Abnormally, with extractions or surgery	☐Yes ☐No	Date_____		Skin Rash	☐Yes ☐No
Blood Disease	☐Yes ☐No	Hepatitis Type _____	☐Yes ☐No	Special Diet	☐Yes ☐No
Cancer	☐Yes ☐No	Herpes	☐Yes ☐No	Stroke	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Swollen Feet or Ankles	☐Yes ☐No
Chemotherapy	☐Yes ☐No	Jaundice	☐Yes ☐No	Swollen Neck Glands	☐Yes ☐No
Circulatory Problems	☐Yes ☐No	Jaw Pain	☐Yes ☐No	Thyroid Problems	☐Yes ☐No
Congenital Heart Lesions	☐Yes ☐No	Kidney Disease	☐Yes ☐No	Tonsillitis	☐Yes ☐No
Cortisone Treatments	☐Yes ☐No	Liver Disease	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Cough, persistent or bloody	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No	Tumor or Growth on Head or Neck	☐Yes ☐No
Diabetes	☐Yes ☐No	Mitral Valve Prolapse	☐Yes ☐No	Ulcer	☐Yes ☐No
Emphysema	☐Yes ☐No	Nervous Problems	☐Yes ☐No	Weight Loss, unexplained	☐Yes ☐No
		Pacemaker	☐Yes ☐No		

Have you had any serious illness or surgery? ☐Yes ☐No Date and Specifics_____

Have you had bisphosphonate therapy (for osteoporosis)? ☐Yes ☐No Avedia or Zometa? ☐Yes ☐No

Have you taken oral bisphosphonates (for osteoporosis)? (Actonel, Boniva, Fosamax, Skelif, Didronel)? ☐Yes ☐No

Have you ever taken any of the group of weight loss drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand name of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Do you wear contact lenses? ☐Yes ☐No

Women: Are you pregnant? ☐Yes ☐No Due Date_____ Are you nursing? ☐Yes ☐No Taking birth control pills? ☐Yes ☐No

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Pharmacy Name _____

Phone (_____)_____

Allergies

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (sedatives) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other_____

☐Latex _____

_____

SIGNATURE_____**DATE**_____